EDMUND G. BROWN JR.
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
KENT D. HARRIS
Deputy Attorney General
State Bar No. 144804
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-7859
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JO LYNN DIAZ** **aka JO LYNN LAPLANTE** **aka JOE LYNN WEINREB** 1200 Creekside Drive, #1014 Folsom, California 95630 **Registered Nurse License No. 643735** Respondent.	Case No. 2011-63 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 26, 2004, the Board issued Registered Nurse License Number 643735 to Jo Lynn Diaz, also known as Jo Lynn Laplante and Joe Lynn Weinreb ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2012, unless renewed.

///

///

///

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Code section 2762 states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

///

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

10. "Methadone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(14).

11. "Norco" is a compound consisting of 10 mg. hydrocodone bitartrate, also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 325 mg. acetaminophen per tablet.

12. "Marijuana" is a Scheduled I controlled substance as designated by Health and Safety Code section 11054(d)(13).

13. "Xanax," a brand of alprazolam, is a Schedule IV controlled substance as defined in Health and Safety Code section 11057(d)(1).

///

///

///

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

14. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that between September 30, 2008, through October 23, 2008, while an employee of Medical Staffing Network (registry), and on assignment as a registry nurse in the Medical/Surgery Unit at Mercy San Juan Hospital, located in Carmichael, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient C:

a. On or about October 9, 2008, at 1344 hours, Respondent signed out one (1) 2 mg. syringe of Morphine. Respondent charted the administration on the patient's Medication Administration Record ("MAR") and nursing notes as having administered the Morphine at 1315 hours, which is 29 minutes prior to signing out the Morphine.

Patient E:

b. On or about September 30, 2008, at 2227 hours, Respondent signed out one (1) .5 mg. tablet of Xanax. Respondent charted the administration on the patient's MAR as having administered the Xanax at 2100 hours, which is 1 hour and 27 minutes prior to signing out the Xanax. In addition, Respondent failed to chart the administration of the Xanax in the patient's nursing notes.

c. On or about September 30, 2008, at 2237 hours, Respondent signed out one (1) 10 mg. tablet of Methadone. Respondent charted the administration on the patient's MAR as having administered the Methadone at 2100 hours, which is 1 hour and 37 minutes prior to signing out the Methadone. In addition, Respondent failed to chart the administration of the Methadone in the patient's nursing notes.

///

///

///

///

Patient F1:

d. On or about October 18, 2008, at 1031 hours, Respondent signed out one (1) 2 mg. syringe of Morphine. Respondent charted the administration of the Morphine at 1043 hours on the patient's MAR. However, Respondent failed to chart the administration of the Morphine in the patient's nursing notes.

e. On or about October 18, 2008, at 1120 hours, Respondent charted the administration of 2 mg. of Morphine on the patient's MAR. However, Respondent did not sign out any Morphine for administration to this patient at that time.

Patient F2:

f. On or about October 18, 2008, at 1120 hours, Respondent signed out one (1) 2 mg. syringe of Morphine without a physician's order, and failed to account for the disposition of the Morphine in any hospital or patient record.

Patient G:

g. On or about October 16, 2008, at 1619 hours, Respondent signed out one (1) 2 mg. syringe of Morphine and charted the administration of the Morphine on the patient's MAR at 1620 hours. Respondent charted the administration of the Morphine at 2300 hours in the patient's nursing notes which is 6 hours and 41 minutes after signing out the Morphine.

h. On or about October 16, 2008, at 1850 hours, Respondent signed out one (1) 2 mg. syringe of Morphine and charted the administration of the Morphine on the patient's MAR at 1915 hours. Respondent charted the administration of the Morphine at 2300 hours in the patient's nursing notes which is 4 hours and 10 minutes after singing out the Morphine.

i. On or about October 16, 2008, at 2226 hours, Respondent signed out one (1) 2 mg. syringe of Morphine. Respondent charted the administration of the Morphine in the patient's nursing notes at 2300 hours, but failed to chart the administration of the Morphine on the patient's MAR.

Patient I:

j. On or about October 16, 2008, at 1719 hours, Respondent signed out one (1) 2 mg. syringe of Morphine, but failed to account for the Morphine in any hospital or patient record.

Patient J:

k. On or about October 23, 2008, at 1500 hours, Respondent charted the administration of two (2) 10 mg. tablets of Norco in the patient's nursing notes. However, no Norco had been signed out by Respondent for this patient.

Patient K:

l. On or about October 23, 2008, at 1453 hours, Respondent documented returning one (1) 10 mg. tablet of Norco; however, Respondent did not sign out Norco for this patient.

SECOND CAUSE FOR DISCIPLINE

(Possessed and Self-Administered a Controlled Substance)

15. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that in 2008 and 2009, while a registered nurse, Respondent did the following:

a. Respondent possessed Marijuana, a controlled substance, in violation of Code section 4060, in that she did not have a prescription for that controlled substance.

b. Respondent self-administered Marijuana, a controlled substance, without direction to do so from a licensed physician and surgeon, dentist or podiatrist.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between September 30, 2008, through October 23, 2008, while an employee of Medical Staffing Network (registry), and on assignment as a registry nurse in the Medical/Surgery Unit at Mercy San Juan Hospital, located in Carmichael, California, Respondent was grossly negligent in the following respects:

Patient C and E:

a. Respondent failed to administer medication in a timely manner, as more particularly set forth above in paragraph 14(a) through (c).

///

///

Patient F1 and F2:

b. Respondent failed to adhere to the Five Rights, which are the right patient, right drug, right dose, right route, and right time, as more particularly set forth above in paragraph 14(d) through (f).

Patient G:

c. Respondent failed to timely chart the administration of Morphine in the patient's nursing notes, and failing to chart the administration of the Morphine on the patient's MAR, as more particularly set forth above in paragraph 14(g), (h), and (i).

Patient I:

d. Respondent failed to chart the administration of Morphine on the patient's MAR, as more particularly set forth above in paragraph 14(j).

Patient J and K:

e. Respondent failed to adhere to the Five Rights, which are the right patient, right drug, right dose, right route, and right time, as more particularly set forth above in paragraph 14(k) and (l).

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that between September 30, 2008, through October 23, 2008, while an employee of Medical Staffing Network (registry), and on assignment as a registry nurse in the Medical/Surgery Unit at Mercy San Juan Hospital, located in Carmichael, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraph 14.

///

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 643735, issued to Jo Lynn Diaz, also known as Jo Lynn Laplante and Joe Lynn Weinreb;

2. Ordering Jo Lynn Diaz, also known as Jo Lynn Laplante and Joe Lynn Weinreb to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/19/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010100337
10575488.doc